TWIN PORTS
WELLNESS +
AESTHETICS

LOOK BETTER, FEEL BETTER,
LIVE BETTER

1728 Tower Ave
Superior WI 54880
(715)395-0928
twinportshealth.com

TWIN PORTS
WELLNESS +
AESTHETICS

Look Better, Feel Better,
Live Better

Your Health, Our Priority

At our health care clinic we want to provide the best care possible to our patients. We are always actively looking for ways to make our patients more comfortable, happier and live their lives to the fullest.

Our team of qualified medical providers have over 20 years of experience over a wide range of subjects. Your health is our biggest priority so we are constantly researching new methods to provide you with better care.

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1728 Tower Avenue Superior, WI 54880

PATIENT INTAKE FORM

Name _____ Date _____

Date of Birth _____ Age _____ Gender _____

Address _____

City _____ State _____ Zip Code _____

Email Address _____ Phone No _____

Emergency Contact _____ Phone No _____

How did you hear about us? _____

Do you consent to receive labs and other information via email (unsecured, not HIPPA protected)? ☐ Yes ☐ No

MEDICAL HISTORY

Are you allergic to any of the following? ☐ GLP-1 Receptor Agonists ☐ Sodium Phosphate

☐ Adhesives/latex ☐ Lidocain/xylocain ☐ Iodine/Betadine ☐ Benzoin

Other allergens: ☐ No ☐ Yes: If yes, please list allergen and reaction:

_____

Are you currently taking blood thinners (i.e., Aspirin/Warfarin), Bexarotene, Gatifloxacin, or any Diabetes medication (i.e. Insulin or sulfonylureas)? ☐ Yes ☐ No

Have you ever been diagnosed with cancer? ☐ Yes ☐ No

Type(s): _____

Date of last Mammogram? _____ Abnormal Findings or Follow up? ☐ No ☐ Yes:

_____

Have you had a colonoscopy? ☐ No ☐ Yes: Date of last colonoscopy? _____

Abnormal Findings or Follow up?

_____

Have you had surgery in the past year? ☐ No ☐ Yes: _____

_____

Have you or a family member been diagnosed with either of the following? ☐ No ☐ Yes:

☐ Multiple Endocrine Neoplasia Syndrome Type 2 (MEN2) ☐ Medullary Thyroid Carcinoma

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PATIENT INTAKE FORM

MEDICAL HISTORY

Please select any relevant conditions below:

- ☐ Adrenal disorder
- ☐ Alopecia (hair loss)
- ☐ Anemia
- ☐ Angina
- ☐ Angioedema
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Autoimmune Disease
- ☐ Breast Cancer
- ☐ Cardiovascular Disease
- ☐ Congestive Heart Failure
- ☐ COPD (chronic obstructive pulmonary disease)
- ☐ Deep vein thrombosis (DVT)
- ☐ Depression/Anxiety
- ☐ Diabetes Type I
- ☐ Diabetes Type II
- ☐ Epilepsy/seizures
- ☐ Endocarditis
- ☐ Gastric/duodenum ulcer
- ☐ Heart failure/valve disease
- ☐ Hemochromatosis
- ☐ High cholesterol
- ☐ HIV/AIDS
- ☐ Hypotension (low BP)
- ☐ Hypertension (elevated BP)
- ☐ Hyperthyroidism (overactive thyroid)
- ☐ Hypothyroidism (underactive thyroid)
- ☐ IBD/IBS
- ☐ Kidney disease
- ☐ Lupus
- ☐ Liver Disease: what type(s):
- ☐ MI / Heart Attack
- ☐ Osteoporosis
- ☐ Pancreatitis
- ☐ Parathyroid disorder
- ☐ PCOS
- ☐ Psychiatric Disorder
- ☐ Pulmonary Embolism
- ☐ Renal failure
- ☐ Sleep Apnea
- ☐ Suicidal Ideation
- ☐ Substance abuse
- ☐ Stroke

Details or any other condition:

_____

_____

FEMALE MEDICAL HISTORY

Are you currently: ☐ Pregnant ☐ Trying to conceive ☐ Breastfeeding ☐ Post-menopause

☐ Using contraceptives: _____ ☐ Other: _____

Date last menses: _____ Pregnancies: _____ Live births: _____

HEALTH HABITS

Do you smoke? ☐ No ☐ Yes How many per day? _____ How long? _____

Do you drink alcohol on a regular basis? ☐ No ☐ Yes Weekly units: _____

Activity level? ☐ Sedentary ☐ Lightly active ☐ Moderately active ☐ Very active

Do you drink caffeine? ☐ Yes ☐ No How much per day?: _____

Date of last physical: _____ Primary Care Provider: _____

Relevant results:

GENERAL MOOD AND FEELINGS

Check the answer that best describes your feeling:

I have little interest or take little prleasure in doing things.

☐ Always ☐ Freqently ☐ Occassionally ☐ Rarely ☐ Never

I feel down, depressed, and hopeless.

☐ Always ☐ Freqently ☐ Occassionally ☐ Rarely ☐ Never

I have trouble falling or staying asleep.

☐ Always ☐ Freqently ☐ Occassionally ☐ Rarely ☐ Never

Family medical history:

☐ Heart Disease ☐ Osteoporosis ☐ Breast Cancer

☐ Diabetes ☐ Alzheimer's/dementia ☐ Other:

Activity Level:

☐ low ☐ moderate ☐ average ☐ high

Marital Status:

☐ Married ☐ Divorced ☐ Widow ☐ Single ☐ Living with Partner

Sexual Health:

☐ I'm sexually active ☐ My sex life has suffered. ☐ I want to be sexually active.

☐ I have difficulty achieving organism ☐ I do not want to be sexually active.

Female Medical History

Have you completed your family?: ☐ Yes ☐ No

Date last menses: _____ Pregnancies: _____ Live births: _____

Are you currently: ☐ Pregnant ☐ Trying to conceive ☐ Breastfeeding ☐ Post-menopause

Are you sexually active? ☐ Yes ☐ No Do you have issues with low sex drive?: ☐ Yes ☐ No

Currently using contraceptives?: ☐ Yes ☐ No Contraceptive Name: _____

Birth control method?: Check below or specify type/method: _____

☐ Menopause ☐ Hysterectomy ☐ Birth Control Pills ☐ Condoms

☐ IUD ☐ Tubal Ligation ☐ Vasectomy ☐ Infertility

☐ Other: _____

Dates & other info (i.e. initiation of pills, IUD placement, ablation, menopause, ect.):

Please select any relevant conditions below:

☐ Uterine Cancer
☐ Uterine fibroids
☐ Endometriosis
☐ Irregular heavy periods
☐ Ophorectomy (removal of ovaries only)
☐ Breast Cancer
☐ History of seizure/epilepsy
☐ Hysterectomy (total) ovaries & uterus
☐ Hysterectomy (partial)Uterus only
☐ Menstral Migraines
☐ Ovarian Cancer
☐ Polycystic Ovaries /PCOS
☐ Painful periods
☐ Irregular periods
☐ Uterine Ablation (when/why?)
☐ Loss of Scalp Hair
☐ Hot Flashes
☐ Breast Cancer
☐ Water weight
☐ Fibromyalgia
☐ Heavy Cycles

Do you take hormones of any kind? ☐ No ☐ Yes: if so, list (include birth control, HRT, natural hormones):

_____

_____

Past BHRT pellet Therapy? ☐ No ☐ Yes: Date/Dose of last pellets?

_____

_____

Male Medical History

Have you completed your family?: ☐ Yes ☐ No Are you sexually active? ☐ Yes ☐ No

☐ I want to be sexually active?

Erectile function (select any relevant symptoms)

☐ Trouble getting an erection during sex?

☐ Erections not hard enough for penetration?

☐ Trouble maintaining erection during sex

☐ Lack of sexual satisfaction from sex

Low Testosterone (select any relevant symptoms):

☐ low sex drive ☐ lost height ☐ low energy ☐ decreased strength

☐ sleep disturbance ☐ less strong erections ☐ sad or grumpy ☐ decreased endurance

☐ hot flashes or night sweats Other:

Please list any specific concerns and questions you want to discuss with provider:

Please select any relevant conditions below:

☐ BPH (prostate enlargement)
☐ Painful urination
☐ cloudy, bloody urine
☐ urinating too often
☐ trouble passing urine
☐ loss of urine (incontinence)
☐ taking medicine for prostate

☐ sleep apnea
☐ had a sleep study: (normal / abnormal)
☐ elevated PSA
☐ Hair loss
☐ Vasectomy
☐ History of anemia
☐ taking medication for male pattern balding

☐ erectile dysfunction
☐ testicular or prostate cancer
☐ kidney disease or decreased function
☐ frequent blood donations
☐ non-cancerous testicular lesions
☐ severe snoring
☐ I wish to have children in the future

Current hormone replacement? ☐ No ☐ Yes: if so, list (all modalities, TRT, HRT, natural hormones):

Past Hormone Therapy? ☐ No ☐ Yes:

Last Pellet therapy? ☐ No ☐ Yes: Date/Dose of last pellets?

WEIGHT HISTORY

Height: **Current Weight:** **BMI:**

How old were you when you first became more than 20 lbs overweight?

Were you overweight as a child? No Yes

What was your highest lifetime weight? What was your Highschool weight?

What factors do you consider contribute to your experience of excess weight?

- Low energy
- Sedentary lifestyle
- Hormonal changes
- Medical condition
- Sleep disruptions
- Alcohol
- Pregnancy
- Stress/busy lifestyle
- Excess calories
- Perimenopause
- Other: _____
- Family history

Have any of your close relatives been overweight or had obesity (check all that apply):

Mother Father Siblings

Does your family support your efforts to have a healthier lifestyle? No Yes

Do you exercise regulary? No Yes What kid of exercise?

How many times per week? How many minutes per session?

Do you work outside your home? No Yes: If yes what type of work?

During the last 3 months, did you have any episodes of excessive overeating?
(i.e., eating significantly more than what most people would east in a similar period of time)

Yes No If yes, about how many times?

Do you sometimes make yourself vomit as a means to control your weight? Yes No

Have you ever been diagnosed with (check all that apply): Bulimia Anorexia Binge eating disorder No

Do you feel distressed about episodes of overeating? Yes No

Do you often feel like you have no control over your eating or cannot stop? Yes No

Are you often embarrassed by how much you eat? Yes No

Do you feel disgusted with yourself for overeating, or do you feel guilty for overindulging? Yes No

Do you avoid social interaction because of your weight? Yes No

Does being overweight cause you to feel depressed? Yes No

WEIGHT HISTORY

Have you ever been treated by a doctor for your weight? Yes No

When? Successful? Yes No How much weight did you loose?

Have you participated in a weight loss program? Yes No

Please indicate which of the following weight loss programs you have tried:

Jenny Craig Weight Watchers Diet Exercise Therapy

Optavia Nutri-system Herbal Supplements Other:

Please indicate which of the following medications you have tried for weight loss:

Phentermine Belviq (lorcaserin) Contrave(naltrexone/bupropion)

Xenical (orlistat) Topamax (topiramate) Saxenda (liraglutide) for weightloss

Other: _____ Victoza (liraglutide) for DM2

Have you ever consulted with a registered dietitian? Yes No

Have you ever had bariatric surgery? Yes No

Have you ever consulted a surgeon regarding bariatric surgery? Yes No

What are your main motivations and concerns for wanting to lose weight with a GLP-1 RA/GIP (Semaglutide/Tirzepatide) medication?

_____

_____

What is your goal Weight? Short term: Long term:

How do you plan to achieve your weight loss goals? (action steps or lifestyle modification):

_____

_____

_____

_____

Please list any specific concerns or questions you want to discuss with provider:

_____

_____

_____

_____

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REVIEW OF SYSTEMS

Eyes

Do you have glaucoma?	Yes	No
Do you have retinopathy? (diabetes-related eye disease)	Yes	No
Do you have blurry vision?	Yes	No

Neurologic

Do you have tingling in your hands or feet?	Yes	No
Do you have hand tremor, or does your hand shake when you hold it out?	Yes	No
Have you ever had migraine headaches?	Yes	No
Do you take medication to prevent migraine headaches?	Yes	No
Have you ever had a seizure?	Yes	No
Have you ever had a stroke or TIA (transient ischemic attack)?	Yes	No

Respiratory

Do you snore?	Yes	No
Have you ever been diagnosed with sleep apnea?	Yes	No
Do you get short of breath when walking?	Yes	No
Do you wheeze?	Yes	No

Cardiac

Have you been diagnosed with angina?	Yes	No
Have you ever had a heart attack?	Yes	No
Have you ever been diagnosed with an arrhythmia (irregular heartbeat)?	Yes	No
Have you ever been told you have a heart murmur?	Yes	No
Do you get short of breath when lying down flat?	Yes	No
Do your feet swell?	Yes	No
Do you ever have palpitations? (racing heart)	Yes	No
Do you ever have chest pain?	Yes	No
Do you take medication for high cholesterol?	Yes	No
Do you take medication for high blood pressure?	Yes	No

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REVIEW OF SYSTEMS

Gastrointestinal

Have you been diagnosed with GERD (gastroesophageal reflux disease?	Yes	No
Do you ever have heartburn?	Yes	No
Have you had gallstones?	Yes	No
Have you had your gallbladder removed (choleysystectomy)?	Yes	No
Have you ever been diagnosed with pancreatitis?	Yes	No
Do you have abdominal pain?	Yes	No
Have you had part of your intestine removed?	Yes	No
Have you been diagnosed with gastroparesis?	Yes	No
Do you frequently have diarrhea?	Yes	No
Do you frequently have nausea?	Yes	No
Do you vomit frequently?	Yes	No

Nephrology

Do you have a history of kidney stones?	Yes	No
Do you have trouble holding your urine?	Yes	No
Do you experience excessive urination?	Yes	No
At night do you wake up to urinate?	Yes	No
Do you ever have blood in your urine?	Yes	No

Musculoskeletal

Do you have a history of arthritis?	Yes	No
Do you have pain in your knees?	Yes	No
Do you have pain in your hips?	Yes	No
Do you have chronic back pain?	Yes	No
Do you have trouble walking or exercising due to joint pain?	Yes	No
Do you take medication for joint or back pain?	Yes	No
Have you had a joint replacement (ex. hip or knee surgery)?	Yes	No

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REVIEW OF SYSTEMS

Endocrine

Have you been told that you have prediabetes?	Yes	No
Do you have dry mouth?	Yes	No
Do you have excessive thirst?	Yes	No
Are you planning to have children within the next year?	Yes	No
Have you been diagnosed with infertility or been told you're infertile?	Yes	No
Do you have low sex drive?	Yes	No

Woman

Do you have acne?	Yes	No
Do you have increased facial hair?	Yes	No
Do you have irregular periods?	Yes	No
Do you have breast pain or have fibrocystic breast disease?	Yes	No

Men

Have you been diagnosed with low testosterone (low-T)?	Yes	No
Have you been diagnosed with erectile dysfunction?	Yes	No

Psychiatric

Have you been diagnosed with anxiety?	Yes	No
Have you been diagnosed with depression?	Yes	No
Have you ever been diagnosed with ADD/ADHD?	Yes	No
Have you ever been diagnosed with bipolar disorder?	Yes	No
Do you have trouble sleeping?	Yes	No
Do you drink more than 2 alcoholic beverages per day?	Yes	No
Do you take pain medication or opiates on a regular basis?	Yes	No
Do you have memory problems?	Yes	No
Do you take medication for depression or anxiety?	Yes	No

Please provide a list of all medications or supplements you take:

MEDICATION OR SUPPLEMENTS	DOSE	FREQUENCY	COMMENTS

By signing below, I acknowledge that I have provided complete and accurate information and understand that it will be used to assess my suitability for any treatment. I understand that it is my responsibility to inform the practitioner of any changes to my medical history or skincare routine. I agree to waive all liabilities of the practitioner or employer for any injury or damages incurred due to misrepresentation of my health history.

Please note that if you contact our provider it may take up to 7-10 business days for her to get back to you for non emergency.

Client Name (printed)	Client Name (signed)	Date
Witness Name (printed)	Witness Name (signed)	Date

TWIN PORTS WELLNESS + AESTHETICS

POLICY FORM

Cancellation

At Twin Ports Wellness and Aesthetics, we strive to provide an exceptional standard of care. We request your cooperation in adhering to our cancellation policy to achieve this.

We understand that life can be unpredictable, and unexpected circumstances may arise. However, please provide us with at least 24 hours' notice if you need to cancel or reschedule your appointment. Your deposit will be refunded or applied to a new appointment.

Cancellations made within 24 hours of the scheduled appointment time are subject to a $50 cancellation fee.

While we understand that unforeseen circumstances can occur, a missed appointment where no notice is given affects our ability to serve other clients and results in lost time and resources. The total cost of the service is charged for these appointments.

We value your time as well as the time of our other clients. If you arrive more than 15 minutes late for your scheduled appointment, we may need to reschedule your session or shorten the treatment duration. The total price of the initially scheduled appointment will still apply.

We truly appreciate your understanding and cooperation in honoring our cancellation policy to ensure each client receives the attention and quality service they deserve.

Client Name (printed)	Client Name (signed)	Date
Witness Name (printed)	Witness Name (signed)	Date

TWIN PORTS WELLNESS + AESTHETICS

MALE PELLET INSERTION CONSENT FORM

My physician/practitioner has recommended testosterone therapy delivered by a pellet inserted under my skin for treatment of symptoms I am experiencing related to low testosterone levels. The following information has been explained to me prior to receiving the recommended testosterone therapy.

OVERVIEW

Bioidentical testosterone is a form of testosterone that is biologically identical to that made in my own body. The levels of active testosterone made by my body have decreased, and therapy using these hormones may have the same or similar effect(s) on my body as my own naturally produced testosterone. The pellets are a delivery mechanism for testosterone, and bioidentical hormone replacement therapy using pellets has been used since the 1930's. There are other formulations of testosterone replacement available, and different methods can be used to deliver the therapy. The risks associated with pellet therapy are generally similar to other forms of replacement therapy using bioidentical hormones.

RISKS/COMPLICATIONS

Risks associated with pellet insertion may include: bleeding from incision site, bruising, fever, infection, pain, swelling, pellet extrusion which may occur several weeks or months after insertion, reaction to local anesthetic and/or preservatives, allergy to adhesives from bandage(s), steri strips or other adhesive agents.

Some individuals may experience one or more of the following complications: acne, anxiety, breast or nipple tenderness or swelling, insomnia, depression, mood swings, fluid and electrolyte disturbances, headaches, increase in body hair, fluid retention or swelling, mood swings or irritability, rash, redness, itching, lack of effect (typically from lack of absorption), transient increase in cholesterol, nausea, retention of sodium, chloride and/or potassium, weight gain or weight loss, thinning hair or male pattern baldness, increased growth of prostate and prostate tumors which may or may not lead to worsening of urinary symptoms, hypersexuality (overactive libido) or decreased libido, erectile dysfunction, painful ejaculation, ten to fifteen percent shrinkage in testicular size, and/or significant reduction in sperm production, increase in neck circumference, overproduction of estrogen (called aromatization) or an increase in red blood cell formation or blood count (erythrocytosis). The latter can be diagnosed with a blood test called a complete blood count (CBC). This test should be done at least annually. Erythrocytosis can be reversed simply by donating blood periodically, but further workup or referral may be required if a more worrisome condition is suspected.

All types of testosterone replacement can cause a significant decrease in sperm count during use. Pellet therapy may affect sperm count for up to one year. If you are planning to start or expand your family, please talk to your provider about other options.

Additionally, there is some risk, even when using bioidentical hormones, that testosterone therapy may cause existing cases of prostate cancer to grow more rapidly. For this reason, a prostate specific antigen blood test (PSA) is recommended for men ages 55-69 before starting hormone therapy, even if asymptomatic. Testing is also recommended for younger individuals considered high risk for prostate cancer. The test should be repeated each year thereafter. If there is any question about possible prostate cancer, a follow-up referral to a qualified specialist for further evaluation may be required.

CONSENT FOR TREATMENT:

I agree to immediately report any adverse reactions or problems that may be related to my therapy to my physician or health care provider's office, so that it may be reported to the manufacturer. Potential complications have been explained to me, and I acknowledge that I have received and understand this information, including the possible risks and potential complications and the potential benefits. I also acknowledge that the nature of bioidentical therapy and other treatments have been explained to me, and I have had all my questions answered.

I understand that follow-up blood testing will be necessary four (4) weeks after my initial pellet insertion and then at least one time annually thereafter. I also understand that although most patients will receive the correct dosage with the first insertion, some may require dose changes.

I understand that my blood tests may reveal that my levels are not optimal which would mean I may need a higher or lower dose in the future. Furthermore, I have not been promised or guaranteed any specific benefits from the insertion of testosterone pellets. I have read or have had this form read to me.

I accept these risks and benefits, and I consent to the insertion of testosterone pellets under my skin performed by my provider. This consent is ongoing for this and all future insertions in this facility until I am no longer a patient here, but I do understand that I can revoke my consent at any time. I have been informed that I may experience any of the complications to this procedure as described above.

I have read or have had this form read to me.

Client Name (printed)	Client Name (signed)	Date	Witness Name (printed)	Witness Name (signed)	Date

TWIN PORTS
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HIPAA Information and Consent Form

Name:_____Date of Birth_____

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services, www.hhs.gov.

The following policies are what we have adopted here at our office:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other health-care providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI, and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S. mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods, or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete, or modify any of these provisions to better serve the needs of both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY AND UNDERSTAND THE INSTRUCTIONS ON THIS FORM.

Print Name_____
Signature_____Date_____

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Hormone Replacement fee acknowledgment and Insurance Disclaimer

Insurance companies are not obligated to pay for our services (consultations, insertions or pellets, injections, Laser or blood work done through our facility). We require payment at time of service and, if you choose, we will provide a form to send to your insurance company with a receipt showing that you paid out of pocket. **WE WILL NOT**, however, communicate in any way with insurance companies.

This form and your receipt are your responsibility and serve as evidence of your treatment. We will not call, write, pre-certify, appeal nor make any contact with your insurance company. If we receive a check from your insurance company, we will not cash it but will return it to the sender. Likewise, we will not mail it to you. We will not respond to any letters or calls from your insurance company.

For patients who have access to Health Savings Account, you may pay for your treatment with that credit or debit card. Some of these accounts require that you pay in full ahead of time, however, and request reimbursement later with a receipt and letter. This is the best idea for those patients who have an HSA as an option in their medical coverage. It is your responsibility to request the receipt and paperwork to submit for reimbursement.

New patient initial pellet fee.....$1200.00
Male hormone pellet re-insertion fee.....$800.00

Client Name (printed)	Client Name (signed)	Date

TWIN PORTS WELLNESS + AESTHETICS

What Might Occur After A Pellet Insertion (Male)

A significant hormonal transition will occur in the first four weeks after the insertion of your hormone pellets. Therefore, certain changes might develop that can be bothersome.

• INFECTION:
Infection is a possibility with any type of procedure. Infection is uncommon with pellet insertion and occurs in <0.5 to 1%. If redness appears and seems to worsen (rather than improve), is associated with severe heat and/or pus, please contact the office. Warm compresses are helpful, but a prescription antibiotic may also be needed.

• PELLET EXTRUSION:
Pellet extrusion is uncommon and occurs in < 5% of procedures. If the wound becomes sore again after it has healed, begins to ooze or bleed or has a blister-type appearance, please contact the office. Warm compresses may help soothe discomfort.

• ITCHING OR REDNESS:
Itching or redness in the area of the incision and pellet placement is common. Some patients may also have a reaction to the tape or glue. If this occurs, apply hydrocortisone to the area 2-3 times daily. If the redness becomes firm or starts to spread, please contact the office.

• FLUID RETENTION/WEIGHT GAIN:
Testosterone stimulates the muscle to grow and retain water which may result in a weight change of two to five pounds. This is only temporary. This happens frequently with the first insertion, and especially during hot, humid weather conditions.

• SWELLING OF THE HANDS & FEET:
This is common in hot and humid weather. It may be treated by drinking lots of water, reducing your salt intake, or by taking a mild diuretic, which the office can prescribe.

• BREAST TENDERNESS OR NIPPLE SENSITIVITY:
These may develop with the first pellet insertion. The increase in estrogen sends more blood to the breast tissue. Increased blood supply is a good thing, as it nourishes the tissue. Taking 2 capsules of DIM daily helps prevent excess estrogen formation. In males, this may indicate that you are a person who is an aromatizer (changes testosterone into estrogen). This is usually prevented if DIM is taken regularly but can be easily treated and will be addressed further when your labs are done, if needed.

• MOOD SWINGS/IRRITABILITY:
These may occur if you were quite deficient in hormones. These symptoms usually improve when enough hormones are in your system. 5HTP can be helpful for this temporary symptom and can be purchased at many health food stores.

• ELEVATED RED BLOOD CELL COUNT:
Testosterone may stimulate growth in the bone marrow of the red blood cells. This condition may also occur in some patients independent of any treatments or medications. If your blood count goes too high, you may be asked to see a blood specialist called a hematologist to make sure there is nothing worrisome found. If there is no cause, the testosterone dose may have to be decreased. Routine blood donation may be helpful in preventing this.

• HAIR LOSS OR ANXIETY:
Is rare and usually occurs in patients who convert testosterone to DHT. Dosage adjustment generally reduces or eliminates the problem. Prescription medications may be necessary in rare cases. 5HTP may be helpful for anxiety and is available over-the-counter.

• FACIAL/BODY BREAKOUT:
Acne may occur when testosterone levels are either very low or high. This lasts a short period of time and can be handled with a good face cleansing routine, astringents and toner. If these solutions do not help, please call the office for suggestions and possibly prescriptions.

• AROMATIZATION:
Some men will form higher-than-expected levels of estrogen from the testosterone. Using DIM 2 capsules daily as directed may prevent this. Symptoms such as nipple tenderness or feeling emotional may be observed. These will usually resolve by taking DIM, but a prescription may be needed.

• HIGH OR LOW HORMONE LEVELS:
The majority of times, we administer the hormone dosage that is best for each patient, however, every patient breaks down and uses hormones differently. Most patients will have the correct dosage the first insertion, but some patients may require dosage changes and blood testing. If your blood levels are low, results are not optimal and it is not too far from the original insertion, we may suggest you return so we can administer additional pellets or a "boost" (at no charge). This would require blood work to confirm. On the other hand, if your levels are high, we can treat the symptoms (if you are having any) by supplements and/or prescription medications. The dosage will be adjusted at your next insertion.

• TESTICULAR SHRINKAGE:
Testicular shrinkage is expected with any type of testosterone treatment.

• LOW SPERM COUNT:
Any testosterone replacement will cause significant decrease in sperm count during use. Pellet therapy may affect sperm count up to one year. If you are planning to start or expand your family, please talk to your provider about other options.

I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY AND UNDERSTAND THE INSTRUCTIONS ON THIS FORM

Client Name (printed)	Client Name (signed)	Date

TWIN PORTS WELLNESS + AESTHETICS

Post-Insertion Instructions for Men

• Your insertion site has been covered with two layers of bandages. The inner layer is a steri-strip, and the outer layer is a waterproof dressing.

• Do not take tub baths or get into a hot tub or swimming pool for 7 days. You may shower, but do not remove the bandage or steri-strips for 7 days.

• No major exercises for the incision area. No heavy lifting using the legs for 7 days. This includes running, elliptical, squats, lunges, etc. You can do moderate upper body work and normal walking on a flat surface.

• The sodium bicarbonate in the anesthetic may cause the site to swell for 1-3 days.

• The insertion site may be uncomfortable for up to 2 to 3 weeks. If there is itching or redness you may take Benadryl for relief (50 mg orally every 6 hours). Caution: this can cause drowsiness

• You may experience bruising, swelling, and/or redness of the insertion site which may last from a few days up to 2 to 3 weeks. If the redness worsens after the first 2-3 days, please contact the office.

• You may notice some pinkish or bloody discoloration of the outer bandage. This is normal.

• If you experience bleeding from the incision, apply firm pressure for 5 minutes. • Please call if you have any bleeding (not oozing) not relieved with pressure, as this is NOT normal.

• Please call if you have any pus coming out of the insertion site, as this is NOT normal.

• We recommend putting an ice pack on the area where the pellets are located a couple of times for about 20 minutes each time over the next 4 to 5 hours. You can continue this for swelling, if needed. Be sure to place something between the ice pack and your bandages/skin. Do not place ice packs directly on bare skin

REMINDERS:

• Remember to have your post-insertion blood work done 4 weeks after your FIRST insertion.
• Most men will need re-insertion of their pellets 4-5 months after their initial insertion. If you experience symptoms prior to this, please call the office.
• Please call as soon as symptoms that were relieved from the pellets start to return to make an appointment for your next insertion.

ADDITIONAL INSTRUCTIONS:

I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY AND UNDERSTAND THE INSTRUCTIONS ON THIS FORM

Client Name (printed)	Client Name (signed)	Date

TWIN PORTS WELLNESS + AESTHETICS

Male Letter of Necessity

Name _____ Date _____

Date of Birth _____ Diagnosis: ICD10 _____

To whom it may concern:

Pellets are derived from natural plant-based ingredients. They are formulated in specialized 503B compounding pharmacies and possess the exact hormonal structure of the human hormone testosterone. These pellets, once implanted, secrete hormones in tiny amounts into the bloodstream constantly. No other form of testosterone delivery, whether injections, gels, sprays, creams, or patches can produce the consistent blood level of testosterone that pellets can. Pellet therapy is the only method of testosterone therapy that gives sustained and consistent testosterone levels throughout the day, for 4 to 6 months, without a "roller coaster" effect. Other forms of testosterone therapy simply cannot deliver such steady hormone levels.

The dosages are individualized by the physician or practitioner for the patient taking into consideration his current and past medical history as well as prior experience with other forms of therapy, current medications, etc. No other form of therapy has unique dosages which can be tailored to each individual patient to suit his special needs.

The above patient was seen in my office and was diagnosed with:

☐ Testosterone deficiency syndrome

His lab values and symptoms are consistent with this diagnosis. Prior to pellet therapy, the patient experienced symptoms such as:

☐ Decreased libido ☐ Lack of mental clarity ☐ Joint pain ☐ Lethargy ☐ Decreased energy ☐ Mood swings

☐ Anxiety ☐ Poor memory ☐ Other: _____

Pellet therapy helps to alleviate these symptoms and helps improve his quality of life both physically and mentally and has benefited his overall well-being. Please honor his request for reimbursment.

Sincerely,

Gina Luna, CNP, NP-C, AANP

TWIN PORTS WELLNESS + AESTHETICS

RELEASE FORM
Photo & Video

I, _____ grant and authorize _____ the right to take, edit, alter, use and publish photographs and/or videos of me for the purpose of promotional materials, including but not limited to:

- Print advertisements
- Online marketing (websites, social media, blogs)
- Educational materials (brochures, flyers, presentations)

I acknowledge that all photographs and/or videos taken are the property of Twin Ports Wellness and Aesthetics and will be used solely for the purposes stated above.

I understand that by signing this release form, I grant Twin Ports Wellness and Aesthetics permission to take, edit, alter, use and publish my photographs and/or videos without any further compensation or consideration. I waive any rights to compensation, financial or otherwise, for the use of these photographs and/or videos.

i release Twin Ports Wellness and Aesthetics, its representatives, and employees from any claims, damages or liabilities that may arise from the use of the photographs and/or videos, including any claims for compensation, defamation, or invasion of privacy.

By signing below, I acknowledge that I have read this release form, understand its content, and voluntarily agree to its terms.

Client Name (printed)	Client Name (signed)	Date
Witness Name (printed)	Witness Name (signed)	Date